		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044818

Facility Name: Elm Brook Healthcare & Rehab Centre

Address: 127 West Diversey Avenue (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630) 530-5225 **Fax #** (630) 530-7775

HFS ID Number: 36-4351749

Date of Initial License for Current Owners: 18th April 2000

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[ ]	Corporation	[ ]	Other ____
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2005 to 31-Dec-2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 31st March 2006 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,705	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,090	4,140	7,545	30,775	8
9	SNF/PED					9
10	ICF	22,870	3,098	91	26,059	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,960	7,238	7,636	56,834	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.51%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 18th April 2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 18th April 2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 117 and days of care provided 6,898

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 31st Dec 2005 Fiscal Year: 31st Dec 2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	311,283	35,336	8,788	355,407		355,407		355,407			1
2	Food Purchase		297,449		297,449	(14,613)	282,836	(341)	282,495			2
3	Housekeeping	256,274	34,243		290,517		290,517		290,517			3
4	Laundry	91,575	33,541		125,116		125,116		125,116			4
5	Heat and Other Utilities			287,189	287,189		287,189		287,189			5
6	Maintenance	69,454	58,779	61,531	189,764		189,764	2,345	192,109			6
7	Other (specify):*											7
8	**TOTAL General Services**	728,586	459,348	357,508	1,545,442	(14,613)	1,530,829	2,004	1,532,833			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,005,954	248,581	136,595	3,391,130		3,391,130		3,391,130			10
10a	Therapy		9,271	2,311	11,582		11,582		11,582			10a
11	Activities	224,576	40,878	9,480	274,934		274,934		274,934			11
12	Social Services	83,280		1,846	85,126		85,126		85,126			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,313,810	298,730	164,632	3,777,172		3,777,172		3,777,172			16
	C. General Administration											
17	Administrative	91,455		287,280	378,735		378,735	(203,776)	174,959			17
18	Directors Fees											18
19	Professional Services			68,751	68,751		68,751	18,265	87,016			19
20	Dues, Fees, Subscriptions & Promotions			51,465	51,465		51,465	(36,428)	15,037			20
21	Clerical & General Office Expenses	174,513	43,015	30,570	248,098		248,098	84,070	332,168			21
22	Employee Benefits & Payroll Taxes			676,191	676,191	14,613	690,804	52,975	743,779			22
23	Inservice Training & Education			1,944	1,944		1,944	1,165	3,109			23
24	Travel and Seminar			7,611	7,611		7,611	5,004	12,615			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,861	61,861		61,861		61,861			26
27	Other (specify):* *Payroll Taxes (Sch VII)							15,002	15,002			27
28	**TOTAL General Administration**	265,968	43,015	1,185,673	1,494,656	14,613	1,509,269	(63,723)	1,445,546			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,308,364	801,093	1,707,813	6,817,270		6,817,270	(61,719)	6,755,551			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre #0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			50,480	50,480		50,480	373,728	424,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,603	85,603		85,603	573,416	659,019			32
33	Real Estate Taxes			49,769	49,769		49,769		49,769			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			3,723	3,723		3,723		3,723			35
36	Other (specify):* *Amortization of Goodwill**			195,618	195,618		195,618		195,618			36
37	TOTAL Ownership			1,885,193	1,885,193		1,885,193	(552,856)	1,332,337			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		229,116	540,638	769,754		769,754		769,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		229,116	639,188	868,304		868,304		868,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,308,364	1,030,209	4,232,194	9,570,767		9,570,767	(614,575)	8,956,192			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,165)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(341)	2		13
14	Non-Care Related Interest	(158,800)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,498)	24		19
20	Contributions	(565)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		21		24
25	Fund Raising, Advertising and Promotional	(61,184)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,851)	20		28
29	Other-Attach Schedule **Page 5A attached**	2,345	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (233,059)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(381,516)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (381,516)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (614,575)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Elm Brook Healthcare & Rehab Centre

ID# 0044818

Report Period Beginning: 1-Jan-2005

Ending: 31-Dec-2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Painting & Decorating (incurred in 2005)	$ (2,480)	6	1
2	Painting & Decorating (allocated for 2005)	4,825	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	2,345		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(341)	0	0	0	0	0	0	0	0	0	0	(341)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,345	0	0	0	0	0	0	0	0	0	0	2,345	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,004	0	0	0	0	0	0	0	0	0	0	2,004	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(203,776)	0	0	0	0	0	0	0	0	0	(203,776)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,465	800	0	0	0	0	0	0	0	0	18,265	19
20	Fees, Subscriptions & Promotions	(64,600)	27,360	812	0	0	0	0	0	0	0	0	(36,428)	20
21	Clerical & General Office Expenses	0	84,070	0	0	0	0	0	0	0	0	0	84,070	21
22	Employee Benefits & Payroll Taxes	0	52,975	0	0	0	0	0	0	0	0	0	52,975	22
23	Inservice Training & Education	0	1,165	0	0	0	0	0	0	0	0	0	1,165	23
24	Travel and Seminar	(2,498)	7,502	0	0	0	0	0	0	0	0	0	5,004	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	15,002	0	0	0	0	0	0	0	0	0	15,002	27
28	**TOTAL General Administration**	(67,098)	1,763	1,612	0	0	0	0	0	0	0	0	(63,723)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,094)	1,763	1,612	0	0	0	0	0	0	0	0	(61,719)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre **#** 0044818 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,165)	542	382,351	0	0	0	0	0	0	0	0	373,728	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(158,800)	3,240	728,976	0	0	0	0	0	0	0	0	573,416	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,500,000)	0	0	0	0	0	0	0	0	(1,500,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(167,965)	3,782	(388,673)	0	0	0	0	0	0	0	0	(552,856)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(233,059)	5,545	(387,061)	0	0	0	0	0	0	0	0	(614,575)	45

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 43,704	$ 43,704	1
2	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	15,002	15,002	2
3	V	17	Management Fee Income	287,280	Lancaster, Ltd.	100.00%		(287,280)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	17,465	17,465	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	84,070	84,070	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	52,975	52,975	6
7	V	24	Seminars & Travel		Lancaster, Ltd.	100.00%	7,502	7,502	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	39,800	39,800	8
9	V	20	Marketing and Fees		Lancaster, Ltd.	100.00%	26,060	26,060	9
10	V	32	Interest	55,193	Lancaster, Ltd.	100.00%	58,433	3,240	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	542	542	11
12	V	20	Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,300	1,300	12
13	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	1,165	1,165	13
14	Total			$ 342,473			$ 348,018	$ * 5,545	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 1,500,000	ElmBrook Associates		$	$ (1,500,000)	15
16	V	32	Interest	89,824	ElmBrook Associates		818,800	728,976	16
17	V	30	Depreciation		ElmBrook Associates		382,351	382,351	17
18	V	20	Licenses and Fees		ElmBrook Associates		812	812	18
19	V	19	Accounting Fees		ElmBrook Associates		800	800	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,589,824			$ 1,202,763	$ * (387,061)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Laurence Zung	Executive Officer	Administrative	33.34%	see attached	2	4.17%	Lancaster	$ 8,750	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	see attached	5	10.42%	Lancaster	17,477	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0.00	see attached	5	10.42%	Lancaster	17,477	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,704		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: -Dec-2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)604-4416
Fax Number: (773)478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 210,000	$ 210,000	2	$ 8,750	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		2	398	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	5	17,477	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		5	931	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	5	17,477	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		5	931	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		287,280	17,465	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	287,280	84,070	14
15	22	Employee Benefits	Management Fees	2,140,820	7	394,769		287,280	52,975	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		287,280	7,502	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	287,280	39,800	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	287,280	26,060	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		287,280	(981)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		287,280	542	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		287,280	1,300	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		287,280	12,742	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		287,280	1,165	23
24	32	*Direct Interest*							59,414	24
25	TOTALS					$ 2,381,147	$ 1,575,768		$ 348,018	25

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	JP Morgan Chase Bank		X	Working Capital							(981)	6
7	Harston Investments		X	Working Capital							660,000	7
8												8
9	TOTAL Facility Related						$	$			$ 659,019	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 659,019	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre **#** 0044818 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 46,750	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 47,519	2
3. Under or (over) accrual (line 2 minus line 1).		$ 769	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 49,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 49,769	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		8
	2001		9
	2002		10
	2003		11
	2004		12

*** Accrual for 2005 report is based on 2004 Taxes adjusted for inflation**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elm Brook Healthcare & Rehab Centre COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044818

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-26-207-022	Long-Term Health Care	$ 3,738.98	$ 3,738.98
2.	03-26-207-025	Long-Term Health Care	$ 43,779.90	$ 43,779.90
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,518.88	$ 47,518.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,800 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

*** None ***

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 21,366
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: None
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility	67,000	2004	$ 565,000	1
2					2
3	TOTALS	67,000		$ 565,000	3

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		2004		$ 6,815,732	$ 174,756	40	$ 174,762	$ 6	$ 283,988	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Front Sign and Awnings			2001	5,750	403	15	403		2,119	9
10	General Construction - Phase I			2001	191,999	4,923	20	4,923		19,897	10
11	Fire Security			2001	9,021	231	20	231		934	11
12	Electrical			2001	3,045	78	20	78		315	12
13	Rehab Satellite			2002	86,171	2,210	10	8,617	6,407	26,569	13
14	General Construction - Phase II			2002	538,782	13,814	10	53,878	40,064	166,124	14
15	Faux Wood Blinds			2003	3,502	336	5	700	364	1,604	15
16	New Roof			2003	36,561	937	10	3,656	2,719	7,617	16
17	Upgrade Elevators			2004	34,190	877	20	1,710	833	1,995	17
18	Construction & Design Cost			2004	15,873	407	10	1,589	1,182	3,167	18
19	Elevator Fire Alarm Equipment			2005	9,360	231	10	936	705	936	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,749,986	$ 199,203		$ 251,483	$ 52,280	$ 515,265	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 912,281	$ 222,855	$ 164,821	$ (58,034)	5	$ 359,572	71
72	Current Year Purchases	39,647	6,877	4,045	(2,832)	5	4,045	72
73	Fully Depreciated Assets	45,771	3,896	3,317	(579)	5	45,771	73
74	**Lancaster Allocation**		542	542			3,479	74
75	TOTALS	$ 997,699	$ 234,170	$ 172,725	$ (61,445)		$ 412,867	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,312,685	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 433,373	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 424,208	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,165)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 928,132	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elmhurst Associates, LLC (a related entity)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,723 Description: E Cylinder (Oxygen) @$4 per cylinder per month & $2 per half month or part thereof.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 250,212	$		$ 250,212	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			26,702			26,702	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			259,863			259,863	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			3,861			3,861	8
9	Pharmacy	39-2	# of prescrpts				147,978		147,978	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**Medical Supplies**	39-2					48,231		48,231	13
	Other (specify): **Speciality Beds**	39-2					32,907		32,907	
14	TOTAL			$		$ 540,638	$ 229,116		$ 769,754	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre **#** 0044818 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 350	$ 5,350	1
2	Cash-Patient Deposits	34,782	34,782	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,327,766	2,327,766	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,734	51,734	6
7	Other Prepaid Expenses	595	595	7
8	Accounts Receivable (owners or related parties)	1,350	1,350	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,416,577	$ 2,421,577	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		565,000	13
14	Buildings, at Historical Cost		6,815,732	14
15	Leasehold Improvements, at Historical Cost	379,600	934,255	15
16	Equipment, at Historical Cost	350,317	997,699	16
17	Accumulated Depreciation (book methods)	(304,832)	(978,548)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,366	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,366)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	2,934,268	2,934,268	22
23	Other(specify): **Goodwill Amortization**	(309,728)	(309,728)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,049,625	$ 10,958,678	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,466,202	$ 13,380,255	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 176,380	$ 194,769	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,782	34,782	28
29	Short-Term Notes Payable	2,901,450	2,794,315	29
30	Accrued Salaries Payable	464,289	464,289	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,584	18,584	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,000	49,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,644,485	$ 3,555,739	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,100,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,100,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,644,485	$ 11,655,739	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,821,717	$ 1,724,516	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,466,202	$ 13,380,255	48

***(See instructions.)**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre **#** 0044818 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,393,174)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,393,174)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(285,109)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	3,500,000	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,214,891	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,821,717	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre **#** 0044818 **Report Period Beginning:** 1-Jan-2005 **Ending:** 31-Dec-2005

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation		
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,377,436)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,377,436)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	101,952	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	5,000,000	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 5,101,952	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,724,516	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,434,831	1
2	Discounts and Allowances for all Levels	(1,784,192)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,650,639	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,380,723	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,380,723	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	209,618	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,382	19
20	Radiology and X-Ray	2,370	20
21	Other Medical Services	33,926	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 254,296	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,285,658	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,545,442	31
32	Health Care	3,777,172	32
33	General Administration	1,494,656	33
	B. Capital Expense		
34	Ownership	1,885,193	34
	C. Ancillary Expense		
35	Special Cost Centers	769,754	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,570,767	40
41	**Income before Income Taxes (line 30 minus line 40)****	(285,109)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (285,109)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. **Cash Basis Taxpaye**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,821	2,086	$ 88,946	$ 42.64	1
2	Assistant Director of Nursing	1,950	2,086	77,146	36.98	2
3	Registered Nurses	36,541	38,117	1,053,659	27.64	3
4	Licensed Practical Nurses	6,992	7,485	158,222	21.14	4
5	CNAs & Orderlies	135,104	143,095	1,604,933	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,839	1,960	26,896	13.72	9
10	Activity Assistants	15,583	16,792	197,680	11.77	10
11	Social Service Workers	4,871	5,101	83,280	16.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,957	34,030	311,283	9.15	15
16	Dishwashers					16
17	Maintenance Workers	4,440	4,787	69,454	14.51	17
18	Housekeepers	26,948	28,539	256,274	8.98	18
19	Laundry	10,176	10,949	91,575	8.36	19
20	Administrator	1,913	2,086	91,455	43.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,376	12,411	174,513	14.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,681	1,790	23,048	12.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	293,192	311,314	$ 4,308,364 *	$ 13.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	266	$ 8,788	1-3	35
36	Medical Director	260	14,400	9-3	36
37	Medical Records Consultant	103	4,048	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	150	2,256	10-3	39
40	Physical Therapy Consultant	67	2,311	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	316	9,480	11-3	44
45	Social Service Consultant	61	1,846	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,223	$ 43,129		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,628	$ 130,291	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,628	$ 130,291		53

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Connie L. Sherman	Administrator	N/A	$ 91,455
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,455

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 287,280
TOTAL (agree to Schedule V, line 17, col. 3)	$ 287,280
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg and Rothblatt	Accounting	$ 1,840
Richard Peelo	Accounting	2,250
Personnel Planners	Unemployment Tax Consult.	1,680
E Health Data Solutions	Data Processing	3,078
Health Data Systems, Inc.	Data Processing	8,198
Accu-med Services, Inc.	Data Processing	3,000
Stone, Pogrund & Korey	Legal	48,705
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 68,751

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,334
Unemployment Compensation Insurance	67,607
FICA Taxes	323,749
Employee Health Insurance	142,457
Employee Meals	14,613
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contributions	12,189
Misc. Employee Benefits	19,999
Employment Fees	26,500
Holiday Expenses	12,356
Lancaster Allocation	52,975
TOTAL (agree to Schedule V, line 22, col.8)	$ 743,779

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N / A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	2,323
Health Care Worker Background Check	3,015
(Indicate # of checks performed 201)	
Licenses and Fees	5,977
Dues and Subscriptions	615
Advertising and Promotions	38,540
Lancaster Allocation	27,360
Elmhurst Associates Allocation	812
Less: Public Relations Expense	(24,031)
Non-allowable advertising	(37,718)
Yellow page advertising	(2,851)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,037

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	579
Seminar Expense	7,032
Lancaster Allocation	7,502
Entertainment Expense	(2,498)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,615

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting & Decorating	5/2003	$ 5,700	3	$	$ 950	$ 1,900	$ 1,900	$ 950	$	$	$	$
2	Painting & Decorating	6/2003	2,050	3		342	683	683	342				
3	Painting & Decorating	2/2004	1,992	3			332	664	664	332			
4	Painting & Decorating	8/2004	1,528	3			255	509	509	255			
5	Painting & Decorating	12/2004	1,968	3			328	656	656	328			
6	Painting & Decorating	3/2005	2,480	3				413	827	827	413		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 15,718		$	$ 1,292	$ 3,498	$ 4,825	$ 3,948	$ 1,742	$ 413	$	$

Facility Name & ID Number Elm Brook Healthcare & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2005 Ending: 31-Dec-2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,996** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,550**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,613** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.